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Developmental Questionnaire

The following questions are asked to help us better understand your child. This information is very important in making an accurate diagnosis and providing recommendations. Please read the questions carefully and answer as fully as possible. We will have the opportunity to discuss these questions in detail at the time of your child's appointment. Thank you.

PLEASE PRINT

CHILD'S NAME _____ TODAY'S DATE _____

SOCIAL SECURITY # _____

BIRTHDATE _____ AGE _____ GRADE _____

CHILD'S HOME ADDRESS _____

HOME PHONE _____ OTHER PHONE _____

EMAIL ADDRESS _____

PERSON COMPLETING FORM _____

DOB _____ SSN _____

RELATIONSHIP TO PATIENT _____

ARE YOU THE CHILD'S LEGAL GUARDIAN? YES NO

IF NO, PLEASE GIVE NAME OF LEGAL GUARDIAN _____

PARENTS' MARITAL STATUS _____ IF MARRIED, HOW LONG? _____

REFERRED BY: _____

ADDRESS: _____

PHONE: _____ FAX: _____

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What are your concerns about this child? What do you feel his/her difficulties/problems are at this time?

What strategies have you tried to help? _____

What questions do you have that you hope this evaluation will answer? _____

Has your child ever been evaluated by a health care or educational professional?

YES _____ NO _____ If yes, please explain (**Please bring a copy of all reports to the evaluation**): _____

Has a psychologist or other professional ever diagnosed this child as having developmental delays and/or learning problems? YES _____ NO _____ If yes, please explain:

What treatment, if any has your child received for the above problems? _____

PLEASE LIST ANY PROFESSIONALS WHO HAVE SEEN THE CHILD/FAMILY:

Name Date(s) seen Procedure (testing, therapy, MRI, EEG)

Father:

Name: _____

Address (if different from child): _____

Telephone (if different from child): HOME _____ WORK _____

Birthdate: _____ Age: _____

Education: _____ Less than High School (_____ years) _____ High School Graduate
_____ Some College _____ 2-year College Degree
_____ 4-year College Degree _____ Graduate School

Occupation/Profession: _____

Current place of employment: _____

Were you ever in any type of special education class? YES ___ NO ___ If yes, please explain: _____

Please indicate if you or any member of *your birth family (Father's family)* has had any of the following:

Condition	Self	Mother	Father	Sibling	Other (please specify)
Attention problems					
Math difficulties					
Reading difficulties					
Writing difficulties					
Discipline problems					
Failing subjects					
Failing grades					
Social problems					

CHILD'S PRENATAL HISTORY

Pregnancy Complications: (Please place an "X" for those that apply to your pregnancy with this child):

X	Condition	X	Condition	X	Condition
	Anemia		High blood pressure		Serious injury
	Confined to bed		High fever		Special diet
	Diabetes		Hospitalizations		Surgery
	Drug/alcohol use/abuse		Incompatible Rh factor		Toxemia
	Depression or Anxiety		Infections		Unusual worries/stress
	Excess weight gain		Morning sickness		Weight loss
	Excessive bleeding		Rubella		Other
	Excessive vomiting		Seizure		

PERINATAL HISTORY

DELIVERY:

Check all that apply to describe the birth of this child:

- | | | |
|---|--|--|
| <input type="checkbox"/> spontaneous delivery | <input type="checkbox"/> breech presentation (feet 1 st) | <input type="checkbox"/> normal presentation |
| <input type="checkbox"/> induced delivery | <input type="checkbox"/> Cesarean section (C-section) | <input type="checkbox"/> use of Pitocin |
| <input type="checkbox"/> forceps used | <input type="checkbox"/> premature delivery (____ weeks) | <input type="checkbox"/> hemorrhage |
| <input type="checkbox"/> late delivery (____ weeks) | <input type="checkbox"/> multiple births (e.g. twins) | <input type="checkbox"/> fetal distress |
| <input type="checkbox"/> general anesthesia | <input type="checkbox"/> local anesthesia (epidural/spinal) | <input type="checkbox"/> vacuum used |
| <input type="checkbox"/> duration of labor (____ hours) | <input type="checkbox"/> muscle relaxant | <input type="checkbox"/> pain medication |

Birth Weight: _____ Length: _____ APGAR Scores: One min. _____ Five min. _____

Place an "X" for any of those that described your child shortly after birth:

- | | | |
|--|---|--|
| <input type="checkbox"/> jaundiced | <input type="checkbox"/> very quiet | <input type="checkbox"/> blood transfusions (baby) |
| <input type="checkbox"/> use of incubator | <input type="checkbox"/> very active | <input type="checkbox"/> problems sucking |
| <input type="checkbox"/> rashes | <input type="checkbox"/> breathing problems | <input type="checkbox"/> use of heart monitor |
| <input type="checkbox"/> problems eating/digestion | <input type="checkbox"/> baby given oxygen | <input type="checkbox"/> Other _____ |

Were there any problems with labor and delivery? YES ___ NO ___ If yes, please explain: _____

Please report any other problems or comments regarding this child when he/she was a newborn: _____

INFANCY AND EARLY CHILDHOOD: (Place an "X" for those items that described your child)

- | | | |
|---|---|---|
| <input type="checkbox"/> Colic | <input type="checkbox"/> Head-banging | <input type="checkbox"/> Feeding problems |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Irritability | <input type="checkbox"/> Restless |
| <input type="checkbox"/> Active | <input type="checkbox"/> Did not enjoy cuddling | <input type="checkbox"/> Accident-prone |
| <input type="checkbox"/> Uncoordinated | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Chronic ear infections |
| <input type="checkbox"/> Other specify: _____ | | |

DEVELOPMENTAL MILESTONES: (Please provide the **approximate age** for each milestone)

Crawled: _____	First syllables ("ma ma"): _____
First steps: _____	First words: _____
Ran: _____	2-3 Word Phrases (e.g. "go bye-bye"): _____
Rode two-wheeler _____	Complete Sentences: _____

Toilet Trained (Day): _____ Toilet Trained (Night): _____

Does your child have wetting or soiling accidents? YES ___ NO ___

Is your child right-handed, left-handed or mixed? _____

Would you describe your child as coordinated/athletic? YES ___ NO ___ Please explain: _____

Please describe any other problems or comments regarding your child's infancy and early childhood development: _____

Describe the best things about your child: _____

Describe your child socially (friends, fights, dating, popularity, participation, etc.): _____

Do you suspect your child to be involved with or experimenting with drugs or alcohol? If yes, please explain. _____

Has your child had any legal problems? (contact with juvenile justice, arrests, etc.) _____

Is your child sexually active? YES ___ NO ___ Does your child smoke? YES ___ NO ___

How would you describe your child's sleep? _____

How would you describe your child's appetite? _____

Please check all that apply to your child:

_____ Mid-night awakenings

_____ Nightmares/night terrors

_____ Difficulty falling asleep
_____ Difficulty waking up

_____ Recent weight gain or loss
_____ Low variety of foods in diet

PRESENT MEDICAL STATUS

Current Health: _____ (Please rate poor, fair, good, excellent, etc.)

Is your child in any way physically ill at this time? YES__ NO__ If yes, please explain and specify if your child is currently being treated for this illness: _____

Is your child currently or previously involved in any type of professional mental health treatment (i.e., therapy, family counseling, etc.)? YES _____ NO _____ If yes, please list:

<u>Clinic</u>	<u>Date(s) seen</u>	<u>Contact Person</u>	<u>Phone Number</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL HISTORY

Has your child undergone any type of surgery? YES _____ NO _____ If yes, please explain: _____

Has your child suffered any type of head injury? YES__ NO__ If yes, please indicate your child's age, how he/she was injured and whether or not consciousness was lost at the time of the incident: _____

Has your child ever experienced convulsions or seizures? YES _____ NO _____ If yes, please indicate the nature of the convulsions and whether or not these occurred with high fevers; please indicate the child's age at the time of the convulsions: _____

Has your child experienced persistent high fevers? YES ___ NO ___ If yes, please explain: _____

Was your child ever in a car when it was in an accident (even a minor one)? YES ___ NO ___ If yes, please explain: _____

Does your child suffer from allergies? YES ___ NO ___ If yes, please explain type of allergic reaction and the treatment he/she is receiving, if any: _____

Has your child suffered from persistent ear infections? YES ___ NO ___ If yes, please explain: _____

Has your child been hospitalized for any illness not covered thus far? YES ___ NO ___
If yes, please explain: _____

Please list any medication your child is currently taking:

<u>Medication</u>	<u>Dose</u> (e.g. 20mg four times a day)	<u>Date Started</u>
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FAMILY HISTORY

Place an "X" next to any medical condition your child or any member of your family has had/has.

<u>X</u>	<u>Condition</u>	<u>X</u>	<u>Condition</u>
	Asthma		Hydrocephalus
	Asperger's Syndrome		Lead poisoning
	Attention Deficit Hyperactivity Disorder		Learning Disability
	Autism/Pervasive Developmental Disorder		Meningitis
	Bipolar Disorder		Mental retardation
	Cerebral palsy		Migraines
	Diabetes		Multiple sclerosis
	Drug or Alcohol Use/Abuse		Neurological Problems
	Emotional problems (depression/anxiety)		Poisoning/Toxic exposure
	Epilepsy		Seizures
	Hearing difficulties		Schizophrenia/psychosis
	Other		Vision difficulties
	Other		

EDUCATIONAL HISTORY:

Name of Current School: _____

Home School District: _____

School Address: _____

Grade Placement: _____

Classroom Type (i.e., regular, LD, resource room, etc.): _____

Number of students in class: _____

Teacher's Name: _____

Principal's Name: _____

School Psychologist or Counselor: _____

Do we have your permission to discuss your child with them? YES ___ NO ___
(If yes, please make sure to sign a Release of Information form)

Has your child ever had an Individual Education Plan (IEP) or Chapter 504 Agreement? YES ___ NO ___

Place an "X" for all/any of the official school classifications that have been assigned to your child:

___ Specific Learning Disability	___ Speech/Language	___ Autistic
___ Emotionally Disturbance	___ Hearing Impaired	___ Visually Impaired
___ Physically Handicapped	___ Mentally Gifted	___ Mentally Deficient
___ Traumatic Brain Injured	___ Multi-handicapped	___ Other _____

Please list the name(s), addresses and telephone numbers of any other persons involved in your child's education who you feel we should contact:
